

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **08635**

8641

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home Frostburg, Md.		d. STREET ADDRESS Box 286	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mable Middle West Last Arnold		4. DATE OF DEATH Month Aug. Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 4 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) New Creek, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachariah Arnold		14. MOTHER'S MAIDEN NAME Anna Saylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nancy Parker Arnold		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of pancreas (b) (Sister) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1 , 19 61 , to 8-15 , 19 61 , that I last saw the deceased alive on 8-14 , 19 61 , and that death occurred at 8-15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. C. Diehl		ADDRESS (Street, city or town, state) Frostburg, Maryland DATE SIGNED 8/16/61	
PHYSICIAN'S NAME (Type) Harold C. Diehl		M.D. 39 W. Main St. Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-61	
22c. NAME OF CEMETERY OR CREMATORY Dulling Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Smith Jr.		ADDRESS Keyser, W. Va.	
24a. REC'D BY REGISTRAR AUG 18 '61		24b. REGISTRAR'S SIGNATURE Charles L. Knecht	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8642 Item 9 Film 6291 9/6/61 mn									
CERTIFICATE OF DEATH									
08636									
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					b. COUNTY ALLEGANY				
c. LENGTH OF STAY IN 1b 3 HRS 45 MIN.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #2, CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL					d. STREET ADDRESS BALTIMORE PIKE				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) BABY BOY					4. DATE OF DEATH Month AUGUST Day 21 Year 1961				
5. SEX MALE					6. COLOR OR RACE WHITE				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					8. DATE OF BIRTH AUGUST 21, 1961				
9. AGE (In years last birthday) yrs. 3 mos. 4 days 45					10. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. CITIZEN OF WHAT COUNTRY? U. S. A.				
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME HARRY W. ATKINSON					14. MOTHER'S MAIDEN NAME LOIS V. MILLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				
16. SOCIAL SECURITY NO.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 2:00 P.M. 19 1961 , to 1961 , that (I) (we) last saw the deceased alive on 1961 , and that death occurred at 1961 , from the causes and on the date stated above.									
22a. SIGNATURE W. Royce Hodges M.D.					22b. DATE SIGNED 8-22-61				
22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES					22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE THEREOF 8-22-61				
23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital					23d. LOCATION (City, town or county) (State) Cumberland, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR DATE AUG 24 '61				
					25b. REGISTRAR'S SIGNATURE Charles E. Hearn				

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ALLERMAN

CUMBERLAND

MEMORIAL & MARSHALL AVES.
MEMORIAL HOSPITAL

HARLAND

RT. 52, CUMBERLAND

BALTIMORE MD

BABY BOY

WHITE

MALE

ATKINSON

AUGUST 21, 1951

CUMBERLAND, MD.

LOIS V. MILLER

HARRY V. ATKINSON

MEMORIAL HOSPITAL - CUMBERLAND, MD.

I

DR. W. ROYCE HODGES

155 S. CENTRE ST., CUMBERLAND, MD.

Memorial Hospital

Cumbers & Co.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08637

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b X Rt. # 4 Cumberland,		d. STREET ADDRESS Irons Mt.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Russell First Middle Last			4. DATE OF DEATH August 24, 1961 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1904	9. AGE (in years, log, & day) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tea Company		11. BIRTHPLACE (State or foreign country) Pendleton Co. W. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Jobe Bible		
14. MOTHER'S MAIDEN NAME Clara Harmon			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. If yes, give war or dates of service		
16. SOCIAL SECURITY NO. 217-10-7206			17. INFORMANT Mrs. Pearl Bible Rt. # 4 Cumberland, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/61	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.			24a. REC'D BY REGISTRAR DATE AUG 28 '61		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



STATE OF MICHIGAN
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

NAME OF DECEASED _____
AGE _____
SEX _____
RACE _____
DATE OF BIRTH _____
PLACE OF BIRTH _____
DATE OF DEATH _____
PLACE OF DEATH _____
CAUSE OF DEATH _____
DIAGNOSIS _____
ATTENDING PHYSICIAN _____
SIGNATURE _____
DATE _____

DECEASED'S RESIDENCE _____
DECEASED'S OCCUPATION _____
DECEASED'S MARITAL STATUS _____
DECEASED'S EDUCATION _____
DECEASED'S RELIGION _____
DECEASED'S ETHNIC ORIGIN _____
DECEASED'S SOCIAL SECURITY NUMBER _____
DECEASED'S MEDICAL HISTORY _____
DECEASED'S PREVIOUS ILLNESSES _____
DECEASED'S PREVIOUS SURGERIES _____
DECEASED'S PREVIOUS TRAUMAS _____
DECEASED'S PREVIOUS DRUG USE _____
DECEASED'S PREVIOUS ALCOHOL USE _____
DECEASED'S PREVIOUS TOBACCO USE _____
DECEASED'S PREVIOUS OTHER HABITS _____
DECEASED'S PREVIOUS ALLERGIES _____
DECEASED'S PREVIOUS MEDICATIONS _____
DECEASED'S PREVIOUS HOSPITAL ADMISSIONS _____
DECEASED'S PREVIOUS SURVIVAL _____
DECEASED'S PREVIOUS DEATHS _____
DECEASED'S PREVIOUS CAUSES OF DEATH _____
DECEASED'S PREVIOUS DIAGNOSES _____
DECEASED'S PREVIOUS TREATMENTS _____
DECEASED'S PREVIOUS OUTCOMES _____
DECEASED'S PREVIOUS COMMENTS _____

1
TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8644 CERTIFICATE OF DEATH 08638											
Items 9 & 14 Film G293 8/30/61 iwk											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>719 Mechanic Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Helen A. Brode</u>				4. DATE OF DEATH <u>August 20, 1961</u>				Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1898</u>		9. AGE (In years last birthday) <u>62 2/3</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John R. Nee (D)</u>				14. MOTHER'S MAIDEN NAME <u>Lucy O'Donnell</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(D)</u>				16. SOCIAL SECURITY NO. <u>Pt's chart</u>				17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 left ventricular failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute posterior myocardial infarction</u> DUE TO (c) <u>myocardial fibrosis -- coronary arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>August 17, 1961 to August 20, 1961</u>		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 20, 1961</u> to <u>August 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 20, 1961</u> , and that death occurred at <u>7:15 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Samuel Jacobson</u>				22b. DATE SIGNED <u>August 20, 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>S. P. Jacobson, M.D.</u>			
22d. ADDRESS <u>59 Pershing St. Cumberland, Md.</u>				22e. REC'D BY REGISTRAR <u>August 28 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Charles L. Hennes</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/23/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter + Paul Cemetery, Md.</u>			
23d. LOCATION (City, town or county) <u>Cumberland, Md.</u>				23e. (State) <u>Md.</u>				23f. (Country) <u>U.S.</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. Your file number should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8645

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford, W. Va. 85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Margaret Middle Catherine Last Carlile		4. DATE OF DEATH Month Aug. Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Own Grocery Store	
11. BIRTHPLACE (State or foreign country) Rio, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Baker		14. MOTHER'S MAIDEN NAME Elizabeth ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Albert Browning		Address Wiley Ford, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC?, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 12, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1961	
22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Gardens		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 16 '61	
24b. REGISTRAR'S SIGNATURE Charles E. Hume			

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>JOHN J. SMITH</u></p>		<p>2. Date of Death: <u>1912</u></p>	
<p>3. Age: <u>45</u> Years</p>		<p>4. Sex: <u>Male</u></p>	
<p>5. Race: <u>White</u></p>		<p>6. Birth Date: <u>1867</u></p>	
<p>7. Birth Place: <u>New York</u></p>		<p>8. Residence: <u>123 Main St., New York</u></p>	
<p>9. Cause of Death: <u>Heart Disease</u></p>		<p>10. Manner of Death: <u>Natural</u></p>	
<p>11. Signature of Medical Examiner: <u>[Signature]</u></p>		<p>12. Date of Examination: <u>1912</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card No. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8646											
08640											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg						c. LENGTH OF STAY IN lb 12 Days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 22 Frostburg					
d. STREET ADDRESS 120 W. Mechanic St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Charles Middle Ruben Last Clark						4. DATE OF DEATH Month August Day 29th Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21st, 1904		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer						10b. KIND OF BUSINESS OR INDUSTRY Street Dept. F'bg. Maryland					
11. BIRTHPLACE (County & State, or foreign country) USA						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Bessie Clark					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 217-10-1617						16. SOCIAL SECURITY NO. Mrs. Edna Clark, Frostburg, Md.					
17. INFORMANT Address 120 W. Mechanic St.						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia + Pericarditis 560.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post Op. Complication - Rt. Hemiplegia 5 days (c) Arteriosclerotic Cardiovascular Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8 p.m. 19						20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/21/61						20f. (City or town) (County) (State) 8/29, 1961					
21. I certify that (I) (this hospital) attended the deceased from 8/21/61 to 8/29, 1961 , that (I) (we) last saw the deceased alive on 8/29, 1961 , and that death occurred at 8/29, 1961 , from the causes and on the date stated above.											
22a. SIGNATURE Martin M. Rothstein, M.D.						22b. DATE / SIGNED 8/30/61					
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein,						22d. ADDRESS 48 Broadway, Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 9-1-61					
23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park						23d. LOCATION (City, town or county) (State) Frostburg, Md.					
24 FUNERAL DIRECTOR'S SIGNATURE J. P. Burt						25a. REC'D BY REGISTRAR SEP 5 '61					
25b. REGISTRAR'S SIGNATURE C. H. S. H. H.											

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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08641

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b NONE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA.		b. COUNTY MINERAL		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 135 MAIN STREET RIDGELEY, W. VA.		d. STREET ADDRESS 135 MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) WILLIAM FOREST CLARK		4. DATE OF DEATH Month AUG.		Day 21		Year 19 61		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16, 1879		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. BOILERMAKER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM H. CLARK		14. MOTHER'S MAIDEN NAME HANNAH POLAND		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-099869		17. INFORMANT FREDERICK T. CLARK		Address KEYSER, W. VA.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO CORONARY SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 21, 1961		ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 24, 1961		22c. NAME OF CEMETERY OR CREMATORY HILL CREST BURIAL PARK		22d. LOCATION (City, town, or country) (State) CUMBERLAND, MD.	
23. FUNERAL DIRECTOR BYRON KIGHT		24a. REC'D BY REGISTRAR AUG 28 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24c. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24d. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24e. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24f. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24g. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24h. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24i. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24j. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8648

CERTIFICATE OF DEATH

08642

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edmund Marvin Conaway</u>		4. DATE OF DEATH Month Day Year <u>August 28, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fairmont, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Conaway</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sturms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-6748</u>	
17. INFORMANT Address <u>Albert W. Conaway, Mt. Savage, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Hemorrhage</u> 2 hrs 443X DUE TO <u>Arteriosclerotic Hypertension Cardiovascular</u> yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> DUE TO <u>Recurrent Cerebral Hemorrhages</u> no III (c) <u>no III</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>61</u> , to <u>8/28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1961</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harvey A. Leigh</u>		22b. DATE <u>8/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARROTHSTEIN M.D.</u>		22d. ADDRESS <u>48 BROADWAY - FROSTBURG MD.</u>	
23a. BURIAL, CREMATION, REMOVAL, ETC. <u>Burial</u>		23b. DATE THEREOF <u>Aug. 31, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>LaVale, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey A. Leigh</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 1 '61</u>	
ADDRESS <u>Hyndman, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8643

CERTIFICATE OF DEATH

08643

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA c. LENGTH OF STAY IN 1b 6 HRS. 20 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W.VA. b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA d. STREET ADDRESS RT#1,			
3. NAME OF DECEASED (Type or print) BABY BOY CRIDER				4. DATE OF DEATH Month AUGUST Day 14 Year 1961		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 14, 1961	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 0 Days 20		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME CURTIS M. CRIDER				14. MOTHER'S MAIDEN NAME BETTY J. MILLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Aspiration Necrosis of the Lung DUE TO (c) Aspiration Necrosis of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 6 hrs 20 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1961, that (I) (we) last saw the deceased alive on 1961, and that death occurred at 3:10 P.M. on the causes and on the date stated above.							
22a. SIGNATURE DR. LELAND RANSOM				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22c. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM				22d. ADDRESS 63 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/15/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem		23d. LOCATION (City, town or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				25a. REC'D BY REGISTRAR AUG 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. King	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8650

CERTIFICATE OF DEATH

08644

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b 2 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 121 Jamesson St.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport d. STREET ADDRESS 121 Jamesson e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rachel S. Davis		4. DATE OF DEATH Month Aug. Day 19 Year 1961					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 5, 1895	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 65 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Rohrbaugh			14. MOTHER'S MAIDEN NAME Maggie Keplinger				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Noah Lease-Westernport, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary carcinoma of vulva DUE TO 176.0 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE James H. Wolverton Jr		22b. DATE SIGNED 8-20-61					
22c. PHYSICIAN'S NAME (Type) J.H. Wolverton Jr M.D.		22d. ADDRESS Piedmont W. Va					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/21/61		23c. NAME OF CEMETERY OR CREMATORY Keplinger Cem.			
23d. LOCATION (City, town or county) Maysville-Grant Ct. W.Va.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR AUG 23 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Krause							

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NOTES ON CONTRIBUTORS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director. For use as the burial-transit permit. Then please remove and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8652 CERTIFICATE OF DEATH 08646

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATTERSON CREEK			
c. LENGTH OF STAY IN 1b 32 DAYS				d. STREET ADDRESS 85X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle J. Last DOHRMAN				4. DATE OF DEATH Month AUGUST Day 24 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 24		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Helper				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) MARYLAND - North Branch	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HERMAN DOHRMAN				14. MOTHER'S MAIDEN NAME MARTHA WAGNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 420.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (c) Arteriosclerotic Heart disease cause last.				INTERVAL BETWEEN ONSET AND DEATH 31 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 61 , to 8/24 , 19 61 , that (I) (we) last saw the deceased alive on 8/24 , 19 61 , and that death occurred at 8 M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. George M. Simons				22b. DATE SIGNED 8/24			
22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-27-1961		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City, town or county) (State) Fort Ashby, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR AUG 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1000

1000

WATSON

WEST VIRG

ALLEGANY

(M)

PATTERSON CREEK

30 DAYS

GENERAL

MEMORIAL & WATSON AVE.
MEMORIAL HOSPITAL

1901

DOYMAN

MENTAL

85

2-10-17

1

WHITE

MALE

MATTHEW HORTON

RECEIVED

RECEIVED

MARTIN WAGNER

RECEIVED

(1)

MEMORIAL HOSPITAL - CLEVELAND, OH.

NO

120 S. CENTRE ST., CLEVELAND, OH.

W. A. WATSON
W. A. WATSON

FORD HOSPITAL, N. Y.

11-23-1901

Part 1

CLEVELAND, OH.

RECEIVED

James F. Scheraga, Jr.,
Cleveland, OH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the law is not followed, the death certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8653

CERTIFICATE OF DEATH

Item 8 Film G292 8/15/61 jwk

08647

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART		d. STREET ADDRESS 70 JANE FRAZIER VILLAGE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MYRTLE M. DUCKWORTH		4. DATE OF DEATH AUGUST 5, 1961		5. AGE (In years if UNDER 1 YEAR; If UNDER 24 HRS. last birthday) Months Days Hours Min. 60 yrs. 60	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (County & State, or foreign country) MARYLAND Cumberland	
13. FATHER'S NAME GEORGE W. LONG		14. MOTHER'S MAIDEN NAME VIRGINIA LONG		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction, left DUE TO (b) Thrombosis of arteries of brain, left Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Essential Hypertension + Diabetes					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 7/14, 1961		20g. (County) 8/5, 1961		20h. (State) 9/30, 1961	
21. I certify that (I) (this hospital) attended the deceased from 7/14, 1961 to 8/5, 1961 , that (I) (we) last saw the deceased alive on 8/5, 1961 , and that death occurred at 9:38 P.M. from the causes and on the date stated above.					
22a. SIGNATURE James H. Scarpelli		22b. SIGNATURE James H. Scarpelli		22c. DATE SIGNED 8/8/61	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D.		22d. ADDRESS 50 Pershing Street		22e. REC'D BY REGISTRAR Arthur S. Kraus	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-9-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.	
23d. LOCATION (City, town or county) Cumberland, Md.		23e. REC'D BY REGISTRAR DATE AUG 10 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Scarpelli					

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

(M)

2553

1931

1

James E. Doerflinger, Esq.
Burial 8-9-31
W. H. Henson, Esq.
Concord, N.H.
Aug. 8, 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in accordance with the law. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8654											
CERTIFICATE OF DEATH											
08648											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY						a. STATE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						b. COUNTY					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
5. SEX						5. AGE (If years)					
6. COLOR OR RACE						6. DATE OF BIRTH					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						7. AGE (If years)					
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. MONTHS					
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						9. HOURS					
10. KIND OF BUSINESS OR INDUSTRY						10. BIRTHPLACE (County & State, or foreign country)					
11. CITIZEN OF WHAT COUNTRY?						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT						18. ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH					
157X						4 MONTHS					
DUE TO						AND GENERALIZED ABDOMINAL METASTASIS.					
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from APRIL 27, 1961, to AUGUST 11, 1961, that (I) (we) last saw the deceased alive on AUGUST 11, 1961, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE											

05228

05228



Chas. E. Kline

05228

James E. Thompson, Jr.

1911-1912

1911-1912

1911-1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8655											
CERTIFICATE OF DEATH											
08649											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 37 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY ROMNEY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 85x-3 d. STREET ADDRESS ROMNEY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DELPHA First M Middle FELLER Last			4. DATE OF DEATH AUGUST Month 30 Day 1961 Year			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH NOV. 23, 1897			9. AGE (In years, last birthday) 63 yrs.			10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) W. VA.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME WILLIAM BEAN					
14. MOTHER'S MAIDEN NAME FLORENCE ELY						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.						17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>hemiparesis and cardiac failure</i> DUE TO CV Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic cholecystitis - cholelithiasis INTERVAL BETWEEN ONSET AND DEATH One month Five years.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug 23 , 19 61 , to Aug 30 , 19 61 , that (I) (we) last saw the deceased alive on Aug 30 , 19 61 , and that death occurred 11:00 AM from the causes and on the date stated above.											
22a. SIGNATURE Carlton Brinsfield M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD						22d. ADDRESS 232 BALTIMORE AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 2, 1961			23c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery			23d. LOCATION (City, town or county) (State) Romney, West Va.		
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hoffer ADDRESS Romney, W. Va.						25a. REC'D BY REGISTRAR DATE SEP 5 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Hoffer		

8055

8055

ALLISON

WEST VIRGINIA

CUMBERLAND

37 DAYS

POWELL

MEMORIAL HOSPITAL

DELPHI

FELDER

AUGUST

WHITE

X

NOV. 22, 1901

NO

WILLIAM BEAN

FLORENCE ELY

MEMORIAL HOSPITAL

CUMBERLAND, MD.

CARLTON EDWARDS

325 BALTIMORE AVE., CUMBERLAND, MD.

Sept. 2, 1901 Indian Mound Cemetery

Wm. J. ...

Roanoke, Va.

Sept. 2, 1901

Cum. ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8656

CERTIFICATE OF DEATH

08650

Item 9 Film 6294 9/16/61 mb

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDWARD		First		Middle		Last		4. DATE OF DEATH AUGUST 27 1961		Month		Day		Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 18, 1893		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired miner				10b. KIND OF BUSINESS OR INDUSTRY Coal mines				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Fields				14. MOTHER'S MAIDEN NAME Emily Mallard				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) none				16. SOCIAL SECURITY NO. none				17. INFORMANT Francis Philpot, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 20 yrs?												INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. X 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8/20, 1961 to 8/27, 1961 , that (I) (we) last saw the deceased alive on 8/27, 1961 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Martin Rothstein M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 8/29/61							
22c. PHYSICIAN'S NAME (Type) Martin Rothstein, M. D.								22d. ADDRESS 48 Broadway, Frostburg, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 30 '61				23c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park				23d. LOCATION (City, town or county) (State) Frostburg, Md.							
24 FUNERAL DIRECTOR'S SIGNATURE J. P. Durst								ADDRESS Frostburg, Md.				25a. REC'D BY REGISTRAR DATE SEP 1 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician. The law also requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law further requires that the death certificate be signed by the attending physician and be completed and filed in by the funeral director. The law also requires that the death certificate be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

Library

Librarian

2 days

Proctoring

Miners Hospital

20

20

20

20

Apr. 18, 1883

White

U.S.A.

Proctoring

Don't know

Proctoring

(L)

Sam's Hall and

Crane's Field

St. I. Box 100

Proctoring, Proctoring, etc.

Proctoring

Proctoring, Proctoring, etc.

Proctoring, Proctoring, etc.

Proctoring, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
8657																			
08651																			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.					c. LENGTH OF STAY IN 1b 1 DAY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS R.F.D.#2, UNION GROVE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ARTHUR JAMES FITCH					4. DATE OF DEATH AUGUST 13, 1961					5. SEX MALE									
6. COLOR OR RACE WHITE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 7-18-1880									
9. AGE (In years less birthday) 81 yrs.					IF UNDER 1 YEAR Months Days Hours Min.					IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plant Mgr.					10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.					11. BIRTHPLACE (County & State, or foreign country) ENGLAND									
12. CITIZEN OF WHAT COUNTRY? England					13. FATHER'S NAME EDWARD A. FITCH					14. MOTHER'S MAIDEN NAME FANNY BELCAM									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL CUMBERLAND, MARYLAND					17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 4 days ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Hypertrophy Prostate. Rt. Hemorrhoids 25 June 1961										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 12 Aug 1961					20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12 Aug 1961					20f. (City or town) (County) (State) 13 Aug 1961									
21. I certify that (I) (this hospital) attended the deceased from 12 Aug 1961 to 13 Aug 1961 that (I) (we) last saw the deceased alive on 12 Aug 1961 , and that death occurred at 8:25 AM from the causes and on the date stated above.										22a. SIGNATURE W. Alfred Van Ormer M.D.					22b. DATE SIGNED 13 Aug 1961				
22c. PHYSICIAN'S NAME (Type) DR. VAN ORMER					22d. ADDRESS 122 So. Centre St. Cumb. Md.					22e. REC'D BY REGISTRAR DATE AUG 17 '61									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8/17/61					23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park									
23d. LOCATION (City, town or county) (State) Cumberland, Md.					24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.					25a. REGISTRAR'S SIGNATURE Arthur L. Kraus									

VR A15 (4)
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1 DAY

CONSTITUTION, NO.

MEMORIAL HOSPITAL

R.T. 1115, UNION GROVE

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GEORGE CORP.

ENGLAND

EDWARD A. FITCH

FANNY FITCH

MEMORIAL HOSPITAL, LIVERPOOL

George Fitch
James Fitch

George Fitch
James Fitch

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DR. VAN COMER

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DR. VAN COMER

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VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician, it is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove this page.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8659

CERTIFICATE OF DEATH

08653

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>57 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>1 509 Valley Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Orando</u> <u>May</u> <u>Griffin</u> First Middle Last 4. DATE OF DEATH <u>August</u> <u>23</u> <u>19</u> <u>61</u> Month Day Year		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-7-1908</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife,</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Arthur Stevens</u> 14. MOTHER'S MAIDEN NAME <u>May Long</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> 16. SOCIAL SECURITY NO. <u>MISS GLADYS STEVENS BRADDOCK RD. CUMB.</u> 17. INFORMANT <u>Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portul Curious</u> <u>581.0</u> DUE TO (b) <u>Portul Curious</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Portul Curious</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portul Curious</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> <u>1961</u> to <u>Aug. 23, 1961</u> that (I) (we) last saw the deceased alive on <u>Aug. 23, 1961</u> and that death occurred at <u>M</u> from the causes and on the date stated above.			
22e. SIGNATURE <u>William P. Jones</u> 22b. DATE SIGNED <u>8/24/61</u>		22c. PHYSICIAN'S NAME (Type) <u>William P. Jones, MD</u> 22d. ADDRESS <u>441 N. Center St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kline</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> DATE <u>AUG 28 '61</u>	

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Miss Alice Stevens or Mrs. J. C. Stevens.

Richard Stevens

Charles L. George, Cumberland, Me.
Rose Hill Cemetery, Cumberland, Me.
March 18/80

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8660

08654

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND 26 DAYS c. LENGTH OF STAY IN 1b 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 721 COLUMBIA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) VIRGINIA ELIZABETH GRIMES		4. DATE OF DEATH Month AUGUST Day 26 Year 19 61		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 28, 1920		9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY				10b. KIND OF BUSINESS OR INDUSTRY MEMORIAL HOSPITAL				11. BIRTHPLACE (County & State, or foreign country) NEBRASKA				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME THOMAS BOYLAND						14. MOTHER'S MAIDEN NAME ELLENORA FLANNAGAN								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma liver (metastatic) DUE TO (b) Carcinoma R+ Breast (adenoca) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schirous Ca Left Breast 1958												INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 to 1959 that (I) (we) last saw the deceased alive on 19 and that death occurred at 2:23 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Fuller B Whitworth M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH						22d. ADDRESS 123 BEDFORD STREET, CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/28/61		23c. NAME OF CEMETERY OR CREMATORY St Patricks Cem.			23d. LOCATION (City, town or county) (State) Cumberland, MD						
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc						ADDRESS Cumb. MD			25a. REC'D BY REGISTRAR AUG 29 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Harris		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law further requires that the death certificate be retained by the hospital or attending physician for use as the burial-transit permit. Then please remove the certificate from the hospital or attending physician's files and file it in the State Department of Health. The law also requires that the death certificate be retained by the hospital or attending physician for use as the burial-transit permit. Then please remove the certificate from the hospital or attending physician's files and file it in the State Department of Health.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8661

CERTIFICATE OF DEATH

08655

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>15 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>126 Arch Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lilly M. Harne</u>		4. DATE OF DEATH <u>August 24 1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7-15-77</u>	
9. AGE (In years last birthday) <u>84</u> yrs. 10. MONTHS <u>24</u> 11. DAYS <u>19</u> 12. HOURS <u>1</u> 13. MIN. <u>1</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>for Sister</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Hagerstown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Andrew Harne (D)</u>		14. MOTHER'S MAIDEN NAME <u>Lana Koontz</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Pt's Chart</u>		17. INFORMANT <u>Pt's Chart</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Uræmia</u> (b) <u>myocarditis & Decompensation</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>12 yrs</u> <u>18 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>No</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1938</u> to <u>Aug 24 1961</u> , that (I) (we) last saw the deceased alive <u>Aug 24 1961</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. C. Durrett</u> M.D.				22b. DATE SIGNED <u>Aug 25 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. C. Durrett</u>	
22d. ADDRESS <u>236 Virginia Ave. Cumberland, Maryland</u>				22e. REC'D BY REGISTRAR <u>SEP 1 '61</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				22g. REGISTRAR'S NAME <u>Arthur S. Kline</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Oakland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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James L. Scoville, Jr.
Oakland, California

James L. Scoville, Jr.
Oakland, California

James L. Scoville, Jr.
Oakland, California

James L. Scoville, Jr.
Oakland, California

James L. Scoville, Jr.
Oakland, California

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08656

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3, Frostburg		c. LENGTH OF STAY IN lb Lifetime		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3, Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) William H. Henckel				4. DATE OF DEATH Month August Day 25th Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13th, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Elevator Opr.			10b. KIND OF BUSINESS OR INDUSTRY K.S. Tire Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William P. Henckel			14. MOTHER'S MAIDEN NAME Emma Logsdon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. W.W. 1 217-10-7231		17. INFORMANT Mrs. May V. Henckel, Rt. 3, F'bg. Md. Box 211		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Artery Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ 15 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. X 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Sept. 1961 , that (I) (we) last saw the deceased alive on 8/25 1961 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Martin M. Rothstein, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/25/61	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein,				22d. ADDRESS 48 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-28-61		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City, town or county) (State) Mt. Savage, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE L. P. Burs				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE AUG 29 '61 Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completed and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8663					CERTIFICATE OF DEATH				
08657									
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
c. LENGTH OF STAY IN 1b 11 DAYS					d. STREET ADDRESS 317 MAGRUDER STREET				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LORETTA					4. DATE OF DEATH 8 30 1961				
5. SEX F					6. COLOR OR RACE W				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 2/20/72				
9. AGE (In years last birthday) 89 yrs.					IF UNDER 1 YEAR: Months 8 Days 30 Hours 19 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Home				
11. BIRTHPLACE (County & State, or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles F. NEUMAN					14. MOTHER'S MAIDEN NAME Mary V. Ogle				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT CHART					Address 13 GREENE STREET				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) osteoporosis of all vertebrae 450.0 DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 19 8-15									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 61 F-30									
20f. (City or town) Agrestown (County) MD (State)									
21. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 61 to 8-30 , 19 61 that (I) (we) last saw the deceased alive on 8-30 , 19 61 and that death occurred at 8-30 , 19 61 M, from the causes and on the date stated above.									
22a. SIGNATURE B. M. Schindler M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22b. DATE SIGNED 9/1/61									
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER									
22d. ADDRESS 13 GREENE STREET									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial									
23b. DATE THEREOF 9/2/61									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.									
23d. LOCATION (City, town or county) Agrestown (State) MD									
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumt, Md.									
25a. RECEIVED BY REGISTRAR SEP 5 1961									
25b. REGISTRAR'S SIGNATURE Arthur S. Thane									

5200

65010

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, and the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. 2, Frostburg,		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle J. Last Hittle				4. DATE OF DEATH Month August Day 20th Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30th, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75	IF UNDER 24 HRS. Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Hittle				14. MOTHER'S MAIDEN NAME Lydia Fox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 199-14-3812		17. INFORMANT Mrs. Allen Stevens, Box 133A, RD2, F'bg., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, MASSIVE 903.0 DUE TO FRACTURE OF LEFT HIP Conditions, if any, which gave rise to immediate cause (b) 4 Days (a), stating the underlying cause last. (c) SUDDEN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME GOING FROM KITCHEN TO BATHROOM					
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. Aug. 16 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rt. 2 FROSTBURG, ALLEG. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		M.D. BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED AUGUST 20, 1961	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) CUMBERLAND, MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-61		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or country) (State) Frostburg Md.	
23. FUNERAL DIRECTOR J. P. Durst				24a. REC'D BY REGISTRAR AUG 23 61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8665

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08659

1. PLACE OF DEATH a. COUNTY <i>Allegheny</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>		c. LENGTH OF STAY IN 1b <i>—</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Miners Hospital Frostburg Md</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>Erie</i>	
3. NAME OF DECEASED (Type or print) <i>Bradley Allan Hoover</i>		4. DATE OF DEATH <i>aug 9 1961</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Erie</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>April 19 1961</i>		9. AGE (In years last birthday) <i>3 yrs 21</i>		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>21</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Erie, Pa.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Alice Laird Hoover</i>		12. CITIZEN OF WHAT COUNTRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Alice Hoover, 1124 West 25th St., Erie, Pa.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>ASPHYXIATION</i>					
DUE TO (b) <i>Aspiration of Stomach Contents</i>					
DUE TO (c) <i>762.0</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W O McLane</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>August 9, 1961</i>	
EXAMINER'S NAME (Type) <i>W.O. McLane, M.D.</i>		Address (Street, city, town, or county) <i>Frostburg, Md.</i>		22. LOCATION (City, town, or country) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-14-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	
23. FUNERAL DIRECTOR <i>HAFFER FUNERAL HOME</i>		24a. REC'D BY REGISTRAR <i>AUG 14 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, and the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8666

08660

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN b. 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover Hills d. STREET ADDRESS 3905 74th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First BETTY Middle JANE Last JENKINS				4. DATE OF DEATH Month August Day 14 Year 19 61									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1930		9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 31 Days 14		IF UNDER 24 HRS. Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Mineral Co. W.Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Abe						14. MOTHER'S MAIDEN NAME Mae Maude Williams							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas Jenkins, Landover Hills, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple sclerosis (b) 345 X Conditions, if any, which gave rise to immediate cause (c) 3 yrs (a), stating the underlying cause last. 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs (b) 3 yrs (c) 3 yrs													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Multiple sclerosis									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/14		20f. (City or town) 8/14		(County) 8/14		(State) 8/14	
21. I certify that (I) (this hospital) attended the deceased from 8/14 to 8/14, 1961, that (I) (we) last saw the deceased alive on 8/14, 1961, and that death occurred at 8/14 from the causes and on the date stated above.													
22a. SIGNATURE B.M. Schindler				22b. DATE SIGNED 8/14/61		22c. PHYSICIAN'S NAME (Type) B.M. Schindler		22d. ADDRESS Cumberland, Maryland		22e. REC'D BY REGISTRAR DATE AUG 18 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Hance	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug 17, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery				23d. LOCATION (City, town or county) Washington D C			
24 FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.						25. REC'D BY REGISTRAR DATE AUG 18 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Hance	

MEDICAL CERTIFICATION

in 24 hours after
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed
may be retained by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and com-

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VR A15
15M 9/6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8667

CERTIFICATE OF DEATH

Items 2 & 8 Film 0294 9/11/61 mh

08661

1. PLACE OF DEATH a. COUNTY <p align="center">ALLEGANY</p>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center">CUMBERLAND</p>		c. LENGTH OF STAY IN b <p align="center">2 DAYS</p>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <p align="center">Pa. MARYLAND</p>		b. COUNTY <p align="center">CATONSVILLE/ Hyndman</p>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <p align="center">MEMORIAL HOSPITAL</p>		d. STREET ADDRESS <p align="center">Rt. 1 SPRING GROVE STATE HOSPITAL</p>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. DATE OF DEATH <p align="center">AUGUST 23 19 61</p>		g. AGE (In years last birthday) <p align="center">36 yrs.</p>		
3. NAME OF DECEASED (Type or print) <p align="center">VIRGINIA F. JOHNS</p>		5. SEX <p align="center">FEMALE</p>		6. COLOR OR RACE <p align="center">WHITE</p>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <p align="center">6-25-1924 1925</p>		
9. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <p align="center">NURSES</p>		10. KIND OF BUSINESS OR INDUSTRY <p align="center">HOSPITAL</p>		11. BIRTHPLACE (County & State, or foreign country) <p align="center">ROMNEY, W.VA.</p>		12. CITIZEN OF WHAT COUNTRY? <p align="center">U.S.A.</p>		13. FATHER'S NAME <p align="center">ELLIS PATTERSON</p>		
14. MOTHER'S MAIDEN NAME <p align="center">GERTRUDE SANDERS</p>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <p align="center">MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</p>		18. INTERVAL BETWEEN ONSET AND DEATH <p align="center">Lungs Skeletal</p>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Generalized Brain DUE TO Carcinoma Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from.....19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at 3:35 A.M. , from the causes and on the date stated above.										
22a. SIGNATURE <p align="center"><i>Fuller B. Whitworth</i> M.D.</p>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <p align="center">DR. FULLER B. WHITWORTH</p>					22d. ADDRESS <p align="center">123 BEDFORD STREET, CUMBERLAND, MD.</p>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">Burial</p>		23b. DATE THEREOF <p align="center">Aug. 26, 1961</p>		23c. NAME OF CEMETERY OR CREMATORY <p align="center">Ebenezer Cemetery</p>		23d. LOCATION (City, town or county) (State) <p align="center">Near Romney, Hampshire, W.Va.</p>				
24. FUNERAL DIRECTOR'S SIGNATURE <p align="center"><i>Robert Sheffer</i></p>					ADDRESS <p align="center">Romney W.Va.</p>		25a. REC'D BY REGISTRAR <p align="center">SEP 6 61</p>		25b. REGISTRAR'S SIGNATURE <p align="center"><i>William S. Hanks</i></p>	

MEDICAL CERTIFICATION

1. This certificate should be detached for use as a burial record. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2057



ALLIANCE

CUMBERLAND

5 DAYS

CATONSVILLE

MEMORIAL HOSPITAL

SPRINGGROVE STATE HOSPITAL

VIRGINIA

F.

JOHN

ST. KRIST

IN

WHITE

FEMALE

WIFE

SPRING GROVE STATE HOSPITAL

GEORGE SWIDERS

ALLIS PATTERSON

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

Handwritten signature: George Swiders

Handwritten signature: Dr. Fuller B. Whitworth

DR. FULLER B. WHITWORTH

152 BEDFORD STREET, CUMBERLAND, MD.

DATE

AUG. 20, 1941

DOCTOR'S CERTIFICATE

HEAR, MARY, CUMBERLAND, MD.

SEP 1 1941

Handwritten signature: George Swiders

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8668 CERTIFICATE OF DEATH 08662														
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL					d. STREET ADDRESS 309 N. DAVIS STREET									
3. NAME OF DECEASED (Type or print) CLARENCE L. JOHNSON					4. DATE OF DEATH AUGUST 12, 19 61									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-1891		9. AGE (In years last birthday) 70 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile					11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME ALBERT JOHNSON					14. MOTHER'S MAIDEN NAME ELIZABETH MARTZELL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 236-03-2418					17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Beriberi (Gruel) 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Gall Bladder DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9:50 P.M.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from 9:50 P.M. to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 , from the causes and on the date stated above.														
22a. SIGNATURE Dr. F. B. Whitworth					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 8/13/61				
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH					22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Aug. 15, 1961					23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.				
23d. LOCATION (City, town or county) Keyser, West Va.														
24. FUNERAL DIRECTOR'S SIGNATURE Geo K. Chambers					ADDRESS Keyser, W. Va.					25a. REC'D BY REGISTRAR AUG 16 '61				
										25b. REGISTRAR'S SIGNATURE Arthur L. Howard				

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WEST VIRGINIA

WEST VIRGINIA

ALLEGANY

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CUMBERLAND

303 W. DAVIS STREET

GENERAL HOSPITAL
1000 W. MARKET AVE.

ALLEGANY

JOHNSON

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WEST VIRGINIA

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ELIZABETH HARTSELL

ALBERT JOHNSON

536-03-1410 GENERAL HOSPITAL - CUMBERLAND, MD.

P.O. R.M.

123 BEDFORD ST., CUMBERLAND, MD.

DR. E. D. WHITWORTH

Keyser, West Va.

Aug. 12, 1901 Queen's Point Cam.

Surf

Aug 18 01

John R. Johnson, White

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8669

CERTIFICATE OF DEATH

08663

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 75X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude ^{First} May ^{Middle} Jordan ^{Last}				4. DATE OF DEATH Month Aug. Day 11 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1890	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done if present, or for the life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U. S. A., Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Tharp				14. MOTHER'S MAIDEN NAME Jane Emerick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Keith Phillips Ellerslie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible acute cerebrovascular accident Approx. 45 min. DUE TO Chronic arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with hypertension DUE TO Arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from approx. 1948 to 8/11/61, that (I) (we) last saw the deceased alive on August 3, 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>John A. Topper</i>				22b. DATE SIGNED 8/11/61		22c. PHYSICIAN'S NAME (Type) John A. Topper, M.D.	
22d. ADDRESS Hyndman, Penna.							
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial				23b. DATE THEREOF 8/14/61		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	
23d. LOCATION (City, town, or county) Hyndman, Bedford Co., Pa.							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey H. Leigler</i>				ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR AUG 14 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneeb</i>							

15283

COMPENSATION

3628

Director

Director

Director

Director

Director

Aug. 11-12

Director

Director

U. S. A. Bureau

U. S. A. Bureau

U. S. A. Bureau

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and the original may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08664

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL - WARWICK AVENUES				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY d. STREET ADDRESS RT. #1. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRED AUSTIN JUDY		4. DATE OF DEATH Month AUGUST Day 29 Year 1961		9. AGE (In years, months, and days) yrs. 64 Months 10 Days 10 Hours 10 Min. 10			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PETERSBURG, W. VA.			
13. FATHER'S NAME ABRAHAM JUDY		14. MOTHER'S MAIDEN NAME BELL HISER		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If assigned or date of service)		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Cerebral hemorrhage, massive Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/19/61 , 19....., to 8/24/61 , 19....., that (I) (we) last saw the deceased alive on 8/24 , 1961, and that death occurred at 5:00 AM on the causes and on the date stated above.							
22a. SIGNATURE William P. James M.D.		22b. DATE SIGNED 8/30/61		22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES			
22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/1961		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.			
23d. LOCATION (City, town or county) Near Cumberland, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 1 '61			
25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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03884



MINERAL

WEST VIRGINIA

ALLEGANY

PODCELY.

10 DAYS

CUMBERLAND

PT. 11.

MEMORIAL HOSPITAL - WARWICK AVENUE

1911

JOHN

AUGUST

1911

SEPTEMBER 13, 1911

MALE WHITE

2.1.

PETERSBURG, VA.

BELL WISER

ABRAHAM JOY

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND



1911

111 N. CENTRE ST., PETERSBURG, VA.

DR. WILLIAM P. JAMES

4/21/1911

CHARLES E. GEORGE, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8671

CERTIFICATE OF DEATH

08665

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 19 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 136 BEDFORD STREET					
3. NAME OF DECEASED (Type or print) CHARLES W. KEITER				4. DATE OF DEATH AUGUST 17 19 61					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 28, 1875			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYE HARVEY'S JEWELRY				10b. KIND OF BUSINESS OR INDUSTRY STORE.		9. AGE (In years last birthday) 86 yrs.			
11. BIRTHPLACE (County & State, or foreign country) FREDERICK COUNTY, VA				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN KEITER				14. MOTHER'S MAIDEN NAME MARY HAMMACK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-05-4274					
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction, general 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Sclerosis (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 19 days 6 months 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 8/17/61 , that (I) (we) last saw the deceased alive on 8/16 , 19 61 , and that death occurred at 2:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. Doerner				22b. DATE SIGNED 8/17/61		22c. PHYSICIAN'S NAME (Type) DR. DOERNER		22d. ADDRESS CUMBERLAND, MARYLAND WASHINGTON & CUMBERLAND STREETS,	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8/19/61		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City, town or county) (State) CUMBERLAND MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE RUTH E. SILCOX				ADDRESS CUMBERLAND MARYLAND		25a. REC'D BY REGISTRAR AUG 21 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Krause	

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ALLEGANY

WESTLAND

ALLEGANY

CH. REWARD

10 DAYS

CHARGE PLAIN

MENTAL HOSPITAL

128 BEDFORD STREET

CHARLES

BEITER

AGUSTE 173

WHITE

JAN. 20, 1943

RETIRED

JOHN W. WELLS

JOHN WELLS

WELLS

MENTAL HOSPITAL - CHARGE PLAIN, PA.

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CHARGE PLAIN

JOHN E. SLOOK

CUMMINGS

THE 21ST

8672

CERTIFICATE OF DEATH

Reg. Dist. No. 08666

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle S. Last KELLER		4. DATE OF DEATH Month 8 Day 19 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (retired)		10b. KIND OF BUSINESS OR INDUSTRY Alteration Dept. Store	
11. BIRTHPLACE (State or foreign country) Eckhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Kellar		14. MOTHER'S MAIDEN NAME Anna Kocsis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8315	
17. INFORMANT Harold Dudley		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) arterio-sclerotic heart disease DUE TO (c) 5-6 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Cardiac hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-9 , 19 61 , to 8-19 , 19 61 , that I last saw the deceased alive on 8-19 , 19 61 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl M.D.		ADDRESS (Street, city or town, state) 39 W. Main St. - Frostburg, Md.	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		DATE SIGNED 8/22/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-22-61	22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. BURIAL DIRECTOR'S SIGNATURE Benjamin H. Montague		24a. REC'D BY REGISTRAR AUG 24 '61	
ADDRESS 23 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

8732

1938

1. Name of deceased: *John A. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *1900-10-15*

5. Date of death: *1938-11-10*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *Dr. J. H. Jones*

9. Signature of registrar: *W. C. Davis*

10. Date of registration: *1938-11-15*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is retained in the hospital or attending physician, this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully pages 1 and 2 and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8673

Item 9 Film G294 9/5/61

CERTIFICATE OF DEATH

08667

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14 West Main		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 14 West Main, Frostburg e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY VINCENT LARGENT		4. DATE OF DEATH 8/26/61 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1886 74 7/5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner (retired)		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	9. AGE (In years last birthday) 74 7/5
11. BIRTHPLACE (County & State, or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Largent		14. MOTHER'S MAIDEN NAME Anna Llewellyn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 191-01-0193	
17. INFORMANT Mrs. Roy V. Largent, 14 West Main		Address Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis 008X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) X 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) X 20c. TIME OF INJURY Month, Day, Year Hour e.m. X 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 8/16/61 to 8/26/61 , that (I) (we) last saw the deceased alive on 8/26/61 , and that death occurred at 5 M, from the causes and on the date stated above. 22a. SIGNATURE Handwritten Signature M.D. 22b. DATE SIGNED 8/29/61 22c. PHYSICIAN'S NAME (Type) Handwritten Signature M.D. 22d. ADDRESS 98 BROADWAY FROSTBURG MD 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE 22g. DATE SEP 1 '61 22h. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesant		24b. ADDRESS 23 E. Main, Frostburg, Md.	

VR A15 (4)
15M 9/60

05581

05581

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Allegany

Prosser

14 West Main

Box

1-22-1933

Allegany (Allegany)

Arthur Jackson

Long

191-01-183

191-01-183

191-01-183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8674

Items 7 & 14 Film G293 8/22/61 mh

08668

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 104 N. Mechanic St.			
3. NAME OF DECEASED (Type or print) John Henry Lindsay				4. DATE OF DEATH August 14 19 61			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-3-1880	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Bill Lindsay				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 150 X			
17. INFORMANT Sacred Heart Hosp. Cumb. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative Recovery Period for Carcinoma of Esophagus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20 1961 to August 14 1961 , that (I) (we) last saw the deceased alive on August 14 1961 , and that death occurred at 3:48 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Calvin Y. Hadidian				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Louis Stein Inc.				22d. ADDRESS Cumb. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/17/61		23c. NAME OF CEMETERY OR CREMATORY Allegany County Cem		23d. LOCATION (City, town or county) (State) Cumb. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				25a. REC'D BY REGISTRAR AUG 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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MEDICAL CERTIFICATION

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Handwritten text at the bottom of the page, possibly a signature or address, including the words "The Bank of" and "New York".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8675

08669

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg				c. LENGTH OF STAY IN 1b 9 Months					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Vale Summit					
3. NAME OF DECEASED (Type or print) Stanley R. Loar				4. DATE OF DEATH Month August Day 24th Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2nd, 1878			
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Blacksmith		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elijah Loar				14. MOTHER'S MAIDEN NAME Emily Morgan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-01-6660				16. SOCIAL SECURITY NO. McKee Loar, Rt. 3, Frostburg, Md.					
17. INFORMANT McKee Loar, Rt. 3, Frostburg, Md.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO (b) Hypertensive Cardio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Senility								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 5-6 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-18 , 19 61 , to 8-24 , 19 61 , that (I) (we) last saw the deceased alive on 8-24 , 19 61 , and that death occurred 10:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE H. C. Diehl				M.D. "		22b. DATE SIGNED 8/25/61			
22c. PHYSICIAN'S NAME (Type) H. C. Diehl				22d. ADDRESS 39 W. Main St., Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-27-61		23c. NAME OF CEMETERY OR CREMATORY M.E. Cemetery		23d. LOCATION (City, town or county) (State) Vale Summit, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Durst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE AUG 29 '61			
				25b. REGISTRAR'S SIGNATURE Arthur L. Hwang					

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Allegany

Allegheny

Allegheny

Vol. 100

9 Months

Vol. 1, Westburg

21

August 2, 1878

1878

Stanley B.

Male White

Aug. 2nd, 1878

USA

Allegheny

Vol. 100

Vol. 100

Early Western

Early Western

214-01-6680 Hoke's Post, St. 1, Westburg, Md.

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B. C. Mohl

N.E. Cemetery

Vol. 100

Vol. 100

Westburg, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08670

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 44 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02 d. STREET ADDRESS 947 MARYLAND AVE., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last MARTIN				4. DATE OF DEATH Month AUGUST Day 4 Year 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 6, 1912		9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND-LITTLE ORLEANS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD R. MARTIN				14. MOTHER'S MAIDEN NAME CHRISTINA SMITH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-12-4957		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 195.0 CARCINOMA OF ADRENAL WITH METASTASIS IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> AUGUST 6, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 7, 1961		22c. NAME OF CEMETERY OR CREMATORY Martin Cemetery		22d. LOCATION (City, town, or county) (State) Little Orleans, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						24a. REC'D BY REGISTRAR DATE AUG 10 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The Registrar may be used as a burial-transit permit. File pages 1 and 2 with Registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely correct. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8677

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08671

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CRESAP TOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 629 MC MULLAN HIGHWAY	
3. NAME OF DECEASED (Type or print) CHARLES J MC DONALD		4. DATE OF DEATH 8 2 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese		10b. KIND OF BUSINESS OR INDUSTRY Textiles	9. AGE (In years last birthday) 68 yrs.
11. BIRTHPLACE (County & State, or foreign country) Franklin, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Mc Donald		14. MOTHER'S MAIDEN NAME Ahmie Faller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 055-07-1176	
17. INFORMANT Charles J. McDonald, Jr.		Address Bowling Green Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary and Hypertensive Cardio-vascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-19-1949 to 8-2-1961 that (I) (we) last saw the deceased alive on 8-2-1961 and that death occurred at 9p.m. from the causes and on the date stated above.			
22a. SIGNATURE Ralph W. Ballin		22b. DATE SIGNED 8-3-61	
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22d. ADDRESS 62 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Ambrose Cemetery		23d. LOCATION (City, town or county) (State) Cresap town, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler		25a. REC'D BY REGISTRAR Aug 7 '61	
ADDRESS Hyndman, Pa.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

(M)

(1)

Yes

WTJ

Charles Mc Donald

Amos Miller

Textiles

Franklin, Pa.

July 14, 1893

055-07-1170 Charles J. McDonald, Jr. Bowling Green

Aug. 2, 1891 St. Ambrose Cemetery Greepstown, Md.

Hyndman, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8678

CERTIFICATE OF DEATH

08672

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 14 Days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital			e. STREET ADDRESS 7 S. Water Street		
3. NAME OF DECEASED (Type or print) Ernest B. McKenzie			4. DATE OF DEATH August 3rd, 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 19th, 1895		9. AGE (in years last birthday) 66 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-Engineering Dept. Celanese Corp.			11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John F. McKenzie		
14. MOTHER'S MAIDEN NAME Annie Loar			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) W.W.1		
16. SOCIAL SECURITY NO. 213-09-6378			17. INFORMANT Mrs. Eva B. McKenzie, 7 S. Water St. F'bg. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalitis 241X } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Broncho Pneumonia (c) Bronchial Asthma			INTERVAL BETWEEN ONSET AND DEATH 2 days 15 days ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg		20g. (County) Frostburg		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 to Aug 3, 1961 , that (I) (we) last saw the deceased alive on Aug 3, 1961 , and that death occurred at Aug 3, 1961 , from the causes and on the date stated above.					
22a. SIGNATURE W. O. McLane			22b. DATE SIGNED Aug 4, 1961		
22c. PHYSICIAN'S NAME (Type) W. O. McLane,			22d. ADDRESS 167 E. Main St., Frostburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-5-61		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	
23d. LOCATION (City, town or county) Frostburg,		23e. (State) Md.		23f. REC'D BY REGISTRAR Aug 7 '61	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Durst		24a. ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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(J)

[Faint, mostly illegible handwritten text and signatures, possibly including names like "W. B. Jones" and "J. B. Jones"]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8679 CERTIFICATE OF DEATH 08673

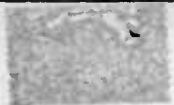
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG-R.F.D. #1				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG- R.F.D. # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First JAMES Middle H. Last MILLER				4. DATE OF DEATH Month AUGUST Day 10 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1888		9. AGE (In years lost birthday) yrs. 73	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINNER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINE		11. BIRTHPLACE (State or foreign country) GILMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE MILLER				14. MOTHER'S MAIDEN NAME VICTORIA BUSKIRK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES *WORLD WAR 1		16. SOCIAL SECURITY NO. 220-10-2722		17. INFORMANT Address MRS. CHARLES BUCKINGHAM, HAGERSTOWN, MD. (DAUGHTER)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5-6 yrs. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1961 , to Aug. 10, 1961 , that (I) last saw the deceased alive on Aug. 7, 1961 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
22a. SIGNATURE H.C. Diehl				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/11/61	
22c. PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.				22d. ADDRESS Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 13, 61		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, LONACONING, MARYLAND				25a. REC'D BY REGISTRAR DATE AUG 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director's name and address on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF DEATH

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M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8680

08674

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 501 N. MECHANIC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FLOYD OSCAR MOORE			4. DATE OF DEATH Month AUGUST Day 13 Year 1961				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1883	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman For Cumberland Contracting Co			10b. KIND OF BUSINESS OR INDUSTRY West Virginia				
11. BIRTHPLACE (Country & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN MOORE (DECEASED)			14. MOTHER'S MAIDEN NAME MARY HIGGINS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) NO			16. SOCIAL SECURITY NO. 218- 34-4632				
17. INFORMANT OLD CHART			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 8/12 , 19 61 , to 8/13 , 19 61 , that (I) (we) last saw the deceased alive on 8/12 , 19 61 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley, Jr., M.D.			22b. DATE SIGNED 8/14/61				
22c. PHYSICIAN'S NAME (Type) LEO H. LEY, JR., M.D.			22d. ADDRESS 456 N. CENTER ST., CUMBERLAND., MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF AUG 15, 1961	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	23d. LOCATION (City, town or county) CUMBERLAND (State) MARYLAND				
24. BURIAL DIRECTOR'S SIGNATURE RUTH E. SILCOX			25a. REC'D BY REGISTRAR AUG 16 '61				
CUMBERLAND MARYLAND			25b. REGISTRAR'S SIGNATURE Arthur L. Hume				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8681

CERTIFICATE OF DEATH

Items 3 & 13 Film 0293 8/28/61 iwk 0293 8/29/61

08675

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/7/1961	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph			Middle Nagy			Last Gnagay		
4. DATE OF DEATH Month August		Day 23		Year 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1876		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Gardener		10b. KIND OF BUSINESS OR INDUSTRY Gardener		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Gnagay Nagy				14. MOTHER'S MAIDEN NAME Veronica unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599,		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Senile degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Senile. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/7/61 19____, to 8/23/61 19____, that (I) (we) last saw the deceased alive on 8/22/61 19____, and that death occurred at ____ M., from the causes and on the date stated above.								
22a. SIGNATURE Dr. Lee B. Mathews		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/23/61				
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/61		23c. NAME OF CEMETERY OR CREMATORY St. Peters Com.		23d. LOCATION (City, town, or county) (State) Westernport Md.		
24. FUNERAL DIRECTOR'S SIGNATURE El. B. B. B.				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE AUG 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus

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HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08676

1. PLACE OF DEATH e. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 515 FURNACE STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA MARY O'BAKER				4. DATE OF DEATH Month AUG. Day 31 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 3, 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AUGUST MACKERT				14. MOTHER'S MAIDEN NAME CATHERINE GRELLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT LAWRENCE O'BAKER CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4 20 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> AUGUST 31, 1961 DATE SIGNED EXAMINER'S SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. Address (Street, city, town, or county) CUMBERLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 4, 1961		22c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY		22d. LOCATION (City, town, or country) (State) CUMBERLAND, MD.	
23. FUNERAL DIRECTOR ADDRESS BYRON KIGHT CUMBERLAND, MD.				24a. REC'D BY REGISTRAR DATE SEP 5 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. H...</i>	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Minutes</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiley Ford</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>85X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>LARUE</u> Last <u>PEER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Edinburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Beddows</u>				14. MOTHER'S MAIDEN NAME <u>Elnora Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Gilbert Carlitz, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA; ACUTE MYOCARDIAL FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>CORONARY SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 14, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. The Registrar should be used as a burial-transit permit. File pages 1 and 2 with Registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8684

CERTIFICATE OF DEATH

08678

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY in 1b 19 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 420 AVIRETT AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY JEANETTE PHILLIPS		4. DATE OF DEATH AUGUST 4, 1961		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 60 10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) W. VA. 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME REV. CHARLES J. PRICE		14. MOTHER'S MAIDEN NAME ANNA V. HALL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X 1 femiplegia Conditions, if any, which gave rise to immediate cause (b) 1 month (c) generalized arteriosclerosis (e), stating the underlying cause last. you PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 9, 1961 to Aug 4, 1961 , that (I) (we) last saw the deceased alive on Aug 4, 1961 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE DR. BLANE SCHINDLER M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8/9/61 22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER 22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park			
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE AUG 10 '61			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(1)

GENERAL HOSPITAL
GENERAL & SURGICAL
10 DAYS

10 DAYS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08679

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pinto near Cresaptown</u>		c. LENGTH OF STAY IN 1b <u>17 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pinto near Cresaptown</u>		d. STREET ADDRESS <u>On farm of J.T. Mason</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>J.</u> Last <u>POLING</u>				4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1943</u>		9. AGE (In years last birthday) <u>17</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Mln. <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Poling</u>				14. MOTHER'S MAIDEN NAME <u>Rose Dawson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Harry Albright, Pinto near Cresaptown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>912.1</u> DUE TO <u>ASPHYXIATION; TRAUMATIC</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>COMPRESSION OF CHEST</u> DUE TO <u>PINNED UNDER OVERTURNED FARM TRACTOR</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-10 Min.</u> <u>5-10 Min.</u> <u>5-10 Min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>Farm tractor overturned pinning deceased under it.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Farm tractor overturned pinning deceased under it.</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:00 a.m. Aug. 3 1961</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Pinto Alleg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 6, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Davis Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 8 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

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(M)

(1)

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Their please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8685

86850

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 4, CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS North Branch		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH WASHINGTON POLLOCK		4. DATE OF DEATH Month AUGUST 29, 1961 Day 19 Year 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) MA Allegany, Md.	
13. FATHER'S NAME ROBERT POLLOCK		14. MOTHER'S MAIDEN NAME EMMA GRACE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-6496		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X DUE TO Cerebral Hemorrhage Generalized Arteriosclerosis DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1961		20g. (County) Allegany		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 8:28 to 8:29 , 19 61 , that (I) (we) last saw the deceased alive on 8:29 , 19 61 , and that death occurred at 8:55 P.M. from the causes and on the date stated above.					
22a. SIGNATURE W. F. Williams		22b. DATE SEP 5 '61		22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
23d. LOCATION (City, town or county) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24b. ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR SEP 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank					

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ALLEGANY

MARYLAND

ALLEGANY

ST. J. CUMBERLAND

1 DAY

CUMBERLAND

MEMORIAL & WILKINS AVES.
MEMORIAL HOSPITAL

AUGUST 22, 1901

POLLOCK

JOSEPH

X

31

1-2-1890

WHITE

MALE

EMERSON GRAVE

ROBERT POLLOCK

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*General Hospital - Cumber-
land, Md.*

122 S. CENTRE ST., CUMBERLAND, MD.

DR. W. F. WILLIAMS

Aug 22

Aug 22

Cumberland, Md.

H. Wayne George

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8687

08681

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE d. STREET ADDRESS RT. #4. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WILLIAM PORTER			4. DATE OF DEATH Month Day Year AUGUST 8 19 61		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH NOVEMBER 10, 1902		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GEORGE G. PORTER		
14. MOTHER'S MAIDEN NAME TILLIE KENNEL			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases DUE TO (b) Carcinoma of Prostate Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from January 19 60 to 8 Aug. 19 61 , that (I) (we) last saw the deceased alive on 8 Aug. 19 61 , and that death occurred at 11:10 AM , from the causes and on the date stated above.					
22a. SIGNATURE James G. Stegmaier M.D.			22b. DATE SIGNED 9 Aug. 61		
22c. PHYSICIAN'S NAME JAMES G. STEGMAIER			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1961		23c. NAME OF CEMETERY OR CREMATORY Temple EUB Cemetery	
23d. LOCATION (City, town or county) Meyersdale, Pa.		(State) Pa.		RD #4	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey L. Leigler			25a. REC'D BY REGISTRAR AUG 14 '61		
25b. REGISTRAR'S SIGNATURE Carlton E. Kline			25c. ADDRESS Hyndman, Pa.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely valid in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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2022



ALLEGANY

PENNSYLVANIA

REYBROOK

1905

CHICAGO

HEYMANN HOSPITAL

ST. 44.

1905

PORTER

WILLIAM

GEORGE

CENTER NO. 100

WHITE

WIFE

MT. SAVAGE, MARYLAND, U.S.A.

THOMAS HENNEL

GEORGE C. PORTER

HEYMANN HOSPITAL, CHICAGO, ILL.

70

1905

WILLIAM

1905

122 S. COOK ST., CHICAGO, ILL.

JAMES C. STEINBERG

Burial Aug. 12, 1901 Temple Hill Cemetery

Reverend Dr. P. H. H. H.

Hartmann, Pa.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 22 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 18 CASTLE HILL	
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH Month AUGUST	
First JOHN		Day 9,	
Middle M.		Year 19 61	
Last RALSTON			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1893
9. AGE (In years less birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY TIRE CO.	
11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY RALSTON		14. MOTHER'S MAIDEN NAME MARGARET BARCLAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 214-05-9619		16. SOCIAL SECURITY NO. 214-05-9619	
17. INFORMANT WARWICK & MEMORIAL AVENUE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Metastasis carcinoma of liver	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/11 1961 to 8/9 1961 , that (I) (we) last saw the deceased alive on 8/8 1961 , and that death occurred at 4:40 A.M. from the causes and on the date stated above		22b. DATE 8/9/61	
22a. SIGNATURE DR. SAMUEL JACOBSON		22c. PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON	
22d. ADDRESS 50 PERSHING STREET, CUMBERLAND, MD.		22e. DATE 8/9/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/1961	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		25a. REC'D BY REGISTRAR DATE AUG 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. REGISTRAR'S SIGNATURE Arthur L. Hines	

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ALLEGANY

WAYNE

ALLEGANY

LOW OIL

SS DYS

CHERRY

BB CASTLE

MEMORIAL HOSPITAL

PAYSON

JOHN

100-100

WHITE

MALE

LOANCOVING, WAYNE

100-100

100-100

MARGARET BARLEY

100-100

WARRICK & HOSPITAL, WAYNE

100-100

100-100

100-100

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100-100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, and the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W.VA. b. COUNTY MINERAL		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keyser		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital--Cumberland, Md.			d. STREET ADDRESS 284 Main St.		
3. NAME OF DECEASED (Type or print) IRA L. RAVENSCROFT			4. DATE OF DEATH Aug. 27 1961		
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1894		9. AGE (in years last birthday) 67 yrs. 2 months 8 days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman			10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad		11. BIRTHPLACE (State or foreign country) McCoope
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Ravenscroft		
14. MOTHER'S MAIDEN NAME Lidia Ravenscroft			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		
16. SOCIAL SECURITY NO. 705-09-7135			17. INFORMANT Memorial Hospital--Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage, bilateral DUE TO 825X Conditions, if any, which gave rise to immediate cause (b) Crushed Chest; Ruptured Right Lung (c) 29 Hrs. DUE TO 29 Hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an Automobile Accident		
20c. TIME OF INJURY Month, Day, Year 11:50 a.m. - Aug. 26 1961			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220 South of Rawlings, Alleg. Md.			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8-30-61		
22c. NAME OF CEMETERY OR CREMATORY Meadow Point Cemetery			22d. LOCATION (City, town, or country) (State) Keyser, W.Va.		
23. FUNERAL DIRECTOR Markwood Fun. Home, Keyser, W. Va.			24a. REC'D BY REGISTRAR AUG 31 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			24c. DATE		

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FOR STAFF
PAGE 10

(M)

ALLIANCE

CHURCHILL

Memorial Hospital--Cumberland, Md. 284 Main St.

THE

MEMORIAL

AND

1901

State

United States

Memorial Hospital

(1)

Memorial Hospital--Cumberland, Md.

Memorial Hospital, Allendale

General Office; Hospital Right Lane

Passenger in an Automobile Accident

11:30--Sun. 28. 31. X. 28. 29. 30. 31. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

Handwritten signature

Handwritten signature, M.D.

X. 28. 29. 30. 31. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

Handwritten signature, M.D.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8690

CERTIFICATE OF DEATH

08684

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			
c. LENGTH OF STAY IN 1b 21 DAYS				d. STREET ADDRESS 702 MARYLAND AVE.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last REAZON ALONZO RUCKMAN			4. DATE OF DEATH Month Day Year AUGUST 3 19 61				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS LEE RUCKMAN				14. MOTHER'S MAIDEN NAME ZELEMA HAINES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 171-10-9246		17. INFORMANT Mrs. Reazon Ruckman Address Cumberland, Md. 702 Maryland Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ASCVD. (c) DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 13, 1961 , to Aug 3, 1961 , that (we) last saw the deceased alive on Aug 3, 1961 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Walter N. Mimmler M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/5/61	
22c. PHYSICIAN'S NAME (Type) DR. WALTER N. MIMMLER				22d. ADDRESS 412 NORTH MECHANIC ST., CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/6/61		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE AUG 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

51 DAYS

CUMBERLAND, MD.

1230 N. JEFFERSON AVE.

105 HUNTERS AVE.

WHITE

5-10-1987

ALLEGANY

ALLEGANY

W.V.

THOMAS LEE RICHMAN

EDWARD H. HARRIS

Handwritten:
A2C V2
A2C V2

Handwritten:
Cigarette / Leaf / Paper

Handwritten:
Walter H. Miller
DR. WALTER H. MILLER

110 WEST HUNTERS ST., CUMBERLAND, MD.

ALLEGANY COUNTY, ALLEGANY, MD.

ALLEGANY COUNTY, ALLEGANY, MD.

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

3691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08685

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY in 1b <u>10 min.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLERSLIE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>EMORY</u> Last <u>SHAFFER</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>5</u> Year <u>19 61</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-12-36</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nevin Araig Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Flossie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1954-57</u>		17. INFORMANT <u>CH ART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGE</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>SKULL FRACTURE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>40 Min.</u> <u>40 Min.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>1:15</u> <u>pm</u> <u>Aug. 5</u> <u>19 61</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 96 near</u>		20f. (City or town) (County) (State) <u>Springtown, Bedford, = Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 5, 1961</u>		Address (Street, city, town, or county) <u>Gumberland, Md.</u>		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa. RD#1</u>	
23. FUNERAL DIRECTOR <u>Lawrence H. Keigler</u>		ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR <u>AUG 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

11/22/53

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Florida Sales

Novin Airline Services

For 1953-54 218-34-1040

Reinstated

Aug. 2, 1951

Porter Cemetery

Initial

Aug. 2, 1951

Initial

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8692

08686

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1 Mi. N. Westernport				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport d. STREET ADDRESS 1 Mi. N. Westernport			
3. NAME OF DECEASED (Type or print) Elmer Middle Bernie Last Sheffler		4. DATE OF DEATH Aug. 13 19 61 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1888	9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ware houseman		
10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Bernie Sheffler			14. MOTHER'S MAIDEN NAME Emily E. Hockman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. I		16. SOCIAL SECURITY NO. 335-10-2220		17. INFORMANT Address Mrs. Anna Sheffler-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 30 mins		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Aug 13, 1961 to Aug 13, 1961 , that (I) (we) last saw the deceased alive on Aug 13, 1961 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE William W. Lesh M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 14, 1961			
22c. PHYSICIAN'S NAME (Type) William W. Lesh		22d. ADDRESS Westernport, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/16/61	23c. NAME OF CEMETERY OR CREMATORY Philos	23d. LOCATION (City, town or county) Westernport (State) Md.				
24 FUNERAL DIRECTOR'S SIGNATURE El. Boral		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE AUG 17 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kram		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1888

1888

(M)

Albany

Albany

Albany - Albany

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely valid in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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060

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8693 CERTIFICATE OF DEATH 08687											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA BEDFORD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN 1b 1 DAY					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL						d. STREET ADDRESS RT. #1, HYNDMAN 75X-3					
3. NAME OF DECEASED (Type or print) STELLA J. SHROYER						4. DATE OF DEATH Month AUGUST 31 Day 19 Year 61					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-1890		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		
13. FATHER'S NAME JOHN EMERICK						14. MOTHER'S MAIDEN NAME EMMA MARTZ					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 9hr					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from 8/30 19 61 to 8/31 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.											
22a. SIGNATURE William P. James						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES DR. X THOMAS X X X X X X X X						22d. ADDRESS 441 N. CENTRE ST. CUMBERLAND, MD WASHINGTON & CUMBERLAND STS., CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/4/61		23c. NAME OF CEMETERY OR CREMATORY Comps Cemetery				23d. LOCATION (City, town or county) (State) Hyndman, Pa. RD#1			
24. FUNERAL DIRECTOR'S SIGNATURE Laverne H. Reigler						ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE SEP 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0003

(M)

ALLEGANY

PENNSYLVANIA

CORPSE

1 DAY

MEMORIAL HOSPITAL
HICKMAN & HICKMAN

PT. ST. SYDNEY

STELLA

SHROYER

AUGUST 21

FEMALE WHITE

10-7-1906

PENNSYLVANIA

Houserville

JOHN EVERICK

EMMA WITZ

MEMORIAL HOSPITAL - CORPSE

NO

(I)

WILLIAM P. HES
DOCKMAN & HICKMAN

Corporal Cemetery
Hickman & Hickman

Hickman, Pa.

10000

10000

(M)

ALLEGANY COUNTY, WEST VIRGINIA

CUSTOMER, HARRISON
HARRISON HOSPITAL, HARRISON, W.V.

DATE: 10-25-1900
WHITE
HARRISON
SLIPPER

RETIRED MAIL CARRIER
HARRISON, GREENSBORO, N.C.

MARY E. SLIPPER
HARRISON HOSPITAL, HARRISON, W.V.

(1)

[Faint, mostly illegible text and signatures follow, including what appears to be a date of 10-25-1900 and a signature.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in and page 3 should be detached for the funeral home. Then please remove carbon papers and return them to the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

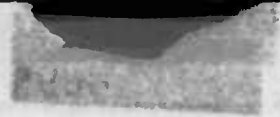
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8695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08689

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Terrace				d. STREET ADDRESS St. Marys Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Agnes Middle A. Last Smith				4. DATE OF DEATH Month August Day 11 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1882	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Garrett County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Weir				14. MOTHER'S MAIDEN NAME Ann McMillian			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sherman Hyde		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) "Daughter" Cerebral vascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Rheumatoid Arthritis - Congestive heart failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 19 56 to Aug. 11 , 19 61 , that (I) (we) last saw the deceased alive on Aug 9 , 19 61 , and that death occurred at 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE L. R. Miles, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8.12.61		22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M. D.	
22d. ADDRESS Lonaconing Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/13/61		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town, or county) (State) Westernport, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE AUG 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Knorr							



Alameda

St. Mary's

St. Mary's

James

White

None

James

NO

*Carroll married at Sacramento
California*

James Carroll married at Sacramento - California

Aug. 1901

William Ford

M. R. Miller, Jr., M.D.

5.17.01

St. Mary's

2
4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08690

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 712 Avondale Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle MARY Last STEGMAIER		4. DATE OF DEATH Month August Day 5 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1876
9. AGE (In years last birthday) 85 yrs.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
13. FATHER'S NAME Joseph Detterman		14. MOTHER'S MAIDEN NAME Barbara Lydinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Edward L. Melvin		Address Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422 (c) ----		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF RIGHT HIP		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL OUT OF BED AT HOME	
20c. TIME OF INJURY Month, Day, Year 4:00 a.m. AUG. 2 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) CUMBERLAND, ALLEG. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> AUGUST 5, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein		24a. REC'D BY REGISTRAR DATE AUG 9 '61	
ADDRESS 117 Frederick St. Cumb. Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8697

08691

M

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART				d. STREET ADDRESS 111 EAST OLDTOWN ROAD			
3. NAME OF DECEASED (Type or print) First ROSE Middle CATHERINE Last THUSS				4. DATE OF DEATH Month AUGUST Day 25 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-29-83	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, Seamstress Self Emp.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES McDERMOTT				14. MOTHER'S MAIDEN NAME Annie Walters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 214-05-4088			
17. INFORMANT CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 332X DUE TO anemia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) cerebral thrombosis (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 7 wks 3 wks 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 25, 1961 to Aug 25, 1961 , that (I) (we) last saw the deceased alive on Aug 24, 1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Clay Durrett				22b. DATE SIGNED Aug 25, 1961		22c. PHYSICIAN'S NAME (Type) Clay Durrett, M.D.	
22d. ADDRESS 236 Virginia Avenue				22e. REC'D BY REGISTRAR SEP 1 '61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-28-61		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. REGISTRAR'S SIGNATURE SEP 1 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

Charles Thompson
Robert Thompson

James P. Campbell

James P. Campbell

James P. Campbell, Cumberland, Md.
B-8-81 St. Mary's Co.
Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8698

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08692

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/26/1961	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 1200 Holland Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Blanch Last Triplett		4. DATE OF DEATH Month August Day 22 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/1872
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kerns, West Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elem Daniels		14. MOTHER'S MAIDEN NAME Luisa Wilmoth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. P.O. Box 599	
17. INFORMANT Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic degenerative 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic, senile. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/26/61 19 to 8/22/61 19, that (I) (we) last saw the deceased alive on 8/22/61 19 at 10:20 A.M. and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 8/23/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/61	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25a. REC'D BY REGISTRAR DATE AUG 28 '61	
ADDRESS Cumberland Md		25b. REGISTRAR'S SIGNATURE Arthur L. Kiser	

9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08693

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND Route #2			
c. LENGTH OF STAY IN 1b 27 HRS.				d. STREET ADDRESS SACRED HEARD HOSPITAL			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle V. Last TURNER				4. DATE OF DEATH Month AUGUST Day 11 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 25, 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7		IF UNDER 24 HRS. Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARTIN KEPLINGER				14. MOTHER'S MAIDEN NAME AMELIA FEASTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMATION CHART							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 260X DUE TO Diabetes mellitus Senescent arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 9, 1961 to August 11, 1961 , that (I) (we) last saw the deceased alive on August 11, 1961 , and that death occurred at 12:55 AM , from the causes and on the date stated above.							
22a. SIGNATURE B. M. Schindler M.D.				22b. DATE SIGNED 8-12-61			
22c. PHYSICIAN'S NAME (Type) Blane M. Schindler M.D.				22d. ADDRESS 43 Green St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUGUST 13, 61		23c. NAME OF CEMETERY OR CREMATORY GLENDALE CEMETERY		23d. LOCATION (City, town or county) (State) FLINTSTONE MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE RUTH E. SILCOX CUMBERLAND MARYLAND				25a. REC'D BY REGISTRAR AUG 15 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

80830

80830

(M)

(J)

U.S. BUREAU OF CONSTRUCTION

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8700
CERTIFICATE OF DEATH
00694

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La VALE				c. LENGTH OF STAY IN 1b 50 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 NATIONAL HIGHWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET E. WAGNER				4. DATE OF DEATH AUG. 9, 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 9, 1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME PATRICK SHERRY				14. MOTHER'S MAIDEN NAME MARGARET BINNIX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. JAMES WILLETTS, LaVALE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3 - 26 19 58 , to 8 - 9 19 61 , that (I) (we) last saw the deceased alive on 8 - 7 19 61 and that death occurred at 9 a M, from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.				22d. ADDRESS 62 Greene St. Cumberland, Md. 8-9-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 11, 1961		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, Md. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT				25a. REC'D BY REGISTRAR DATE AUG 14 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kiana							

BP

STATE OF TEXAS

1900

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician's office, the certificate may be retained by the hospital or attending physician and completed and filed in by the funeral director. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

3701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08695

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN TB 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 1300 LEXINGTON AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN HENRY WHITACRE		4. DATE OF DEATH Month AUGUST Day 10 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14 1876
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (County & State, or foreign country) W.VA. OKONOKO
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN WHITACRE	
14. MOTHER'S MAIDEN NAME MARY SIRBAUGH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. John Armentrout		Address Cumb. Md. 1300 Lexington Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.01 DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. — p.m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. City or town (County) (State) Cumby Alley Md
21. I certify that (I) (this hospital) attended the deceased from 8/10/61 , 19 1961 , to 8/10/61 , 19 1961 , that (I) (we) last saw the deceased alive on 8/10/61 , 19 1961 , and that death occurred 12:10 PM from the causes and on the date stated above.			
22a. SIGNATURE R.J. WILLIAMS		22b. DATE SIGNED 8/11/61	22c. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/13/61	23c. NAME OF CEMETERY OR CREMATORY Abe. Cemetery
23d. LOCATION (City, town or county) (State) Near Ridgeley, W. Va.		24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George	
25a. REC'D BY REGISTRAR AUG 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

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GENERAL HOSPITAL

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133 S. CENTRE ST., CUMBERLAND, MD.

R. J. WILLIAMS

W. M. DEWITT

8/12/02

W. M. DEWITT

CHARLES E. GEORGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08696

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES DEWEY WILLIAMS		4. DATE OF DEATH 8/8/1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road Engineer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ocean, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Williams		14. MOTHER'S MAIDEN NAME Elizabeth Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-07-1517	
17. INFORMANT Mr. James E. Williams,		Address Midland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 min 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 8 , 1961, to Aug 8 , 1961, that (I) (we) last saw the deceased alive on June 30 , 1961, and that death occurred at 12:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Worme Page		22b. DATE SIGNED Aug 8 1961	
22c. PHYSICIAN'S NAME (Type) Worme Page MD		22d. ADDRESS Frostburg MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/10/1961	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		25a. REC'D BY REGISTRAR DATE AUG 11 '61	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 5 Film G295 8/26/61 iwk

08697

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 320 SCHLEY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILBUR First B. V. Middle WILSON Last		4. DATE OF DEATH AUGUST 20, 1961 Month 20 Day 1961 Year		9. AGE (In years last birthday) 77 7/8 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH SEPT. 3, 1883		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		11. BIRTHPLACE (County & State, or foreign country) PAW PAW, W. VA.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME OLIVER WILSON		14. MOTHER'S MAIDEN NAME Emma Fisher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute left ventricular failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) acute posterior myocardial infarction DUE TO (c) myocardial fibrosis -- coronary arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH instant 24 hrs. ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) January 30, 1961, to August 20, 1961			
20f. (City or town) Cumberland, MD		20g. (County) Allegany		20h. (State) MD			
21. I certify that (I) (this hospital) attended the deceased from August 19, 1961 , to August 20, 1961 , that (I) (we) last saw the deceased alive on August 19, 1961 , and that death occurred at 9:00AM from the causes and on the date stated above.							
22a. SIGNATURE DR. SAMUEL M. JACOBSON M.D.		22b. DATE August 20, 1961		22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON			
22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.		22e. REC'D BY REGISTRAR DATE AUG 23 '61					
22f. REGISTRAR'S SIGNATURE Arthur S. Kraus		22g. REGISTRAR'S NAME Arthur S. Kraus					
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.			
23d. LOCATION (City, town or county) Cumberland, MD		23e. LOCATION (State) MD					
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc - Cumb. MD		24a. ADDRESS Cumb. MD		24b. DATE AUG 23 '61			
24c. REGISTRAR'S SIGNATURE Arthur S. Kraus		24d. REGISTRAR'S NAME Arthur S. Kraus		24e. REGISTRAR'S ADDRESS Cumb. MD			

MEDICAL CERTIFICATION

3173



ALLGAIN

IRRYLAND

CAMERLAND

CUMBERLAND

WASHICK & HENRIAL AVENUES
HOSPITAL

380 SCHLEY STREET

WILSON

WILSON

HAIR

WHITE

SEPT. 3, 1886

PAW PAT. W. W.

OLIVER WILSON

HOSPITAL - CUMBERLAND, MD.

acute postoperative myocardial infarction

myocardial infarction -- coronary arteriosclerosis

myocardial infarction -- coronary arteriosclerosis

August 20, 1911

August 10, 1911

DR. SAMUEL H. JACKSON

2 FRESHWATER ST., CUMBERLAND, MD.

Handwritten notes and signatures at the bottom of the page, including "August 10, 1911" and "August 20, 1911".

8704

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08698

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 7/25/1961			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle L. Last Wilt				4. DATE OF DEATH Month August Day 20 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1896	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Railroad Engineer			10b. KIND OF BUSINESS OR INDUSTRY Bond, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME James Alexander Wilt			14. MOTHER'S MAIDEN NAME Sarah Frances Foutz				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. P.O.Box 599		17. INFORMANT Address Cumberland, Md. Allegany County Infirmary records.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, obs. Secile DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, secile (c) cerebral apoplexy, left hemiplegia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Westernport	(County) md.		(State)	
21. I certify that (I) (this hospital) attended the deceased from 7/25/61 19 to 8/20/61 19, that (I) (we) last saw the deceased alive on 8/19/61 19, and that death occurred at 6:50 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee B. Mathews				22b. DATE SIGNED 8/21/61		22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/61		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION (City, town, or county) (State) Westernport, md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal				25a. REC'D BY REGISTRAR DATE AUG 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

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James Alexander

James Alexander

P.O. Box 22

Allegany County, West Virginia

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Mr. J. B. Alexander